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AUTHORIZATION TO RELEASE DENTAL INFORMATION

The execution of this form does not authorize the release of information other than that specifically described below.

Patient _____

Date of Birth _____ S.S. # _____

Release records from: _____

Release records to: _____

I request and authorize the above named doctor or healthcare provider to release the information specified below to the organization, agency, or individual named in this request.

Information Requested:

☐ Copy of complete orthodontic records (photographs, models, x-rays)
☐ Copy of x-rays: _____
☐ Copy of dental chart: _____

Purpose or need for which information is to be used:

☐ Transfer of records
☐ Second opinion
☐ Other

Authorization: *I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.*

Signature_____ Date_____